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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/13/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Right shoulder arthroscopy, subacromial decompression

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is this reviewer's opinion the right shoulder arthroscopy, subacromial decompression would not be considered medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who was injured on xx/xx/xx while xxxxxx. The patient developed complaints of pain in the right shoulder. This pain persisted despite an initial six sessions of physical therapy and over the counter medications. The patient began seeing in February 2014 and initial MR arthrogram studies of the right shoulder completed on 07/24/14 noted a partial thickness tear of the distal supraspinatus tendon with severe tendinosis. There was some thickening of the subscapularis tendon. The patient was continued on several medications including oral steroids, narcotic analgesics, anti-inflammatories, and muscle relaxers.

The patient underwent an extensive period of physical therapy in 2014 and 2015. A repeat MR arthrogram of the right shoulder completed on 04/02/15 noted a moderate to large amount of bursal effusion within the rotator cuff with supraspinatus and infraspinatus tendinosis. There was also a prior tenodesis noted at the biceps tendon. The findings included a superior labral tear and no evidence of a recurrent rotator cuff tear. The 08/27/15 clinical record by noted persistent right shoulder pain despite recent physical therapy. The patient's physical examination noted mild tenderness over the right shoulder with limited range of motion actively on flexion to 90 degrees. Passively the patient could obtain full flexion. Some limited passive external rotation to 60 degrees was noted. The patient had a right sided positive empty can test as well as positive impingement signs. The patient received a steroid injection at this evaluation. Surgical intervention to include subacromial decompression was discussed. The requested subacromial decompression of the right shoulder was denied by utilization review on 09/16/15 as there were issues with post-operative physical therapy compliance and lack of a recent discussion regarding a response to subacromial injections. The request was again denied on 09/25/15 as there was still no documentation regarding response to subacromial injections.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient continued to report right shoulder pain despite conservative intervention to include physical therapy and medications. It is unclear from the clinical records what the response was to the subacromial injection completed in August of 2015. Although the patient's physical examination on in August of 2015 noted positive impingement signs, recent MR arthrogram studies of the right shoulder did not identify any significant impingement due to abnormal acromion formation. Given that this is a third surgical request, no indication of significant improvement from prior surgeries, and there is no documentation regarding a response to the recent subacromial injection, it is this reviewer's opinion the right shoulder arthroscopy, subacromial decompression would not be considered medically necessary based on guideline recommendations. Therefore the prior denials would remain upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)